Department of Health
Child and Adolescent Mental Health Division

Performance Report

Performance Period April 2003-June 2003

Introduction

This report presents information about the performance of operations and services of the Child and Adolescent Mental Health Division (CAMHD) during the fourth quarter of fiscal year 2003 (April 2003-June 2003). As timely information is needed to assess present performance, this report presents the most current data available. Where possible, data are aggregated at both statewide and district or complex levels.

Data are presented in four major areas: Population, Service, Cost, and Performance. Population information describes the characteristics of the children, youth, and families that are served. Service information is compiled regarding the type and amount of direct care services that are used by children, youth, and families. Cost information is gathered about the financial aspects of services. Performance Measures, including Outcome data, are collected to track and understand the quality of services and the performance of operations of the statewide infrastructure needed to provide supports for children, youth, and families. Outcomes are further examined to determine the extent to which services provided lead to improvements in the functioning and satisfaction of children, youth and families.

CAMHD Performance Measures are established through two criteria. The first criteria are measures linked to former Benchmarks or regular reports to the Court. These measures were formerly used to gauge compliance with the Felix Consent Decree. By December 2002, all CAMHD Benchmarks reported to the Court were deemed to be "completed" or "completed and ongoing." These measures are seen as those most closely tied to demonstrating sustainability. For CAMHD, the Benchmarks and reports to the Court were:

1) CAMHD outcome and results components will be implemented (Benchmark 22).
2) CAMHD will have developed appropriate CSPs for all children whose care is coordinated by CAMHD (Benchmark 26).
3) Service gap analysis (unserved youth report) will document that no child will wait longer than 30 days for a specified service or appropriate alternative…CAMHD will document in the quality improvement reviews that appropriate referrals are being made (Benchmarks 33 and 54-deemed completed)
4) Personnel and Vacancy Reporting
5) Benchmarks that describe complex service testing
6) Complaints (no Benchmark attached, reporting requested by Felix Monitoring Project).

The second criteria CAMHD employs to select measures is whether indicators focus the service system on core areas of service provision and supporting infrastructure. These measures are chosen to coordinate the work of the organization in order to ultimately achieve timely, cost-effective services that improve the lives of children, youth and families served. Measures were selected to organize work around strategic goals, and to promote accountability for results around these goals. Performance measures provide data-driven information that allow for the evaluation of quality and results through objective data. Although not all indicators link directly to former Court Benchmarks, they are measures of a sustainable system of mental health services that engages in continuous quality monitoring in order to achieve goals and implement improvements.

As presented in previous reports, this comprehensive data set is used both internally by CAMHD to make decisions about services, and to allow all CAMHD stakeholders to view the core aspects of service delivery and performance of the mental health service system for children, youth and families. A primary use of data is to inform continuous improvement efforts at all levels. CAMHD's internal quality management structure includes a Performance Improvement Steering Committee (PISC) that reports to the CAMHD Executive Management Team. PISC and its subcommittees receive performance data and reports regarding the quality and effectiveness of care across the service system, and recommend the implementation of accountable improvements throughout the organization and service system. Performance reporting about client status, care and service delivery is assessed to determine priorities for improvement, including areas that would benefit from focused study. The PISC monitors and evaluates actions taken to improve performance.

Another important use of performance data is at the Family Guidance Centers (FGCs). Branch Chiefs and supervisors are able to access timely data relevant to center and staff performance. Local-level managers are also able to monitor regional and statewide trends and performance expectations, which further supports planning and decisions.

Data Sources

The primary source for data regarding the population served, access and use of services, cost, treatment processes and outcomes is generated at the Family Guidance Centers or through billing information, and collected through the Child and Adolescent Mental Health Management Information System (CAMHMIS). CAMHMIS has the ability to produce data reports that are used by staff and management for tracking, decision-making, supervision and evaluation. CAMHMIS has multiple features, including the ability to generate "live" client and FGC-specific reports. Additional data elements used to track Performance Measures are produced by various databases maintained at the State Level. Client-specific and aggregate reports are used by staff at all levels.

Population Characteristics

Population data reflect the fourth quarter of fiscal year 2003 (April-June 2003) for youth registered in the CAMHD Family Guidance Centers. In the quarter, CAMHD Family Guidance Centers provided care coordination for 1,794 youth across the State, an increase of 42 over the third quarter.

The total number of registered youth are described by four subgroups: (*i*) youth who received both intensive case management services and direct services authorized through the CAMHD provider network, (*ii*) youth who were in the process of having services arranged (new admissions), (*iii*) youth who received less intensive services through Mokihana on Kauai, and (*iv*) youth who were discharged at some time during the quarter. There was also a percentage of youth who received case management services only. Of the total registered youth, 955 had services that were authorized within the quarter.

Of the registered population (1,794), 143 youth (8%) were newly registered in the fourth quarter of fiscal year 2003. This represents slightly more (9) new admissions than the third quarter, but 72 more than the first quarter of the fiscal year. This may represent a stabilization of new admissions for the Family Guidance Centers. The primary growth in new admissions came through the Family Court Liaison Brand (FCLB). The number of admission the FCLB increased dramatically due to more youth accessing services primarily while placed at the Detention home.

One hundred forty-three (143) youth (6%) who had previously received services from CAMHD were reregistered in CAMHMIS, which was similar to last quarter's readmissions of 153 youth. CAMHD discharged a total of 238 youth during the quarter or 13.3% of the registered population. Again, this compares closely to last quarter's discharge of 238 (13.5% of the registered population).

Of the 955 youth who had services authorized in the quarter, 51 received new admissions (5.3%), 759 repeat admissions and 90 discharges (9.4%). There were 39 more youth with services authorized discharged than admitted in the period. It is important to note that because youth may receive multiple admissions or discharges during the quarter for administrative reasons, these numbers estimate, but do not exactly reflect changes in the overall registered population size.

The average age of youth registered in the reporting quarter was 14.5 years with a range from 4 to 20 years. As displayed in Table 1, the majority of the youth were male (68%). More males than females has been a consistent feature of the CAMHD population, and is typical of most children's mental health systems.

Table 1. Gender of CAMHD Youth

Gender	N	% of Available
Females	572	32%
Males	1,222	68%

CAMHD youth may also have involvement by other public child-serving agencies including the Department of Human Services (DHS), Family Court, Hawaii Youth Correctional Facility (HYCF) or Detention Home, or are QUEST-eligible (see Table 3). Of the youth who had services authorized in the quarter, 14.8% were involved with DHS, 31.5% had a Family Court hearing during the quarter, and 9.9% were incarcerated at HYCF or the Detention Home. QUEST-eligible youth represented approximately 39.6% of the CAMHD population, an increase of 9.7% or 103 Quest-eligible youth over last quarter. CAMHD continues to receive Federal Medicaid reimbursement to provide behavioral health services within the CAMHD array

Table 2. Agency Involvement of Youth with Authorized Services

Agency Involvement	N	%
DHS	141	14.8%
Court	301	31.5%
Incarcerated	95	9.9%
Quest	378	39.6%

of services under the Medicaid state plan for rehabilitative services. A key provision of the MOA now allows QUEST-eligible youth with Severe Emotional and Behavioral Disturbance to receive services through CAMHD. A child's Quest Health plan, child-serving agency or other referral sources can directly refer youth for a determination of eligibility for intensive mental health services. Because a growing segment of the Medicaid population are children and youth with psychiatric disabilities, this access to CAMHD services is critical for eligible children and youth with severe and chronic mental health issues.

Table 3 describes the various ethnicities of youth who received authorizations for services in the reporting quarter. Those with Mixed ethnicities represented the largest group (26.3%), closely followed by youth of Hawaiian ethnicity (25.4%). Caucasian made up the third largest ethnic group (21.2%), followed by Filipino (7.8%) and Japanese (4.8%).

Ethnicity	N	% of Available
African-American	25	3.1%
African, Other	2	0.2%
American Indian	3	0.4%
Asian, Other	8	1.0%
Caucasian, Other	182	22.3%
Chamorro	0	0.0%
Chinese	5	0.6%
Filipino	62	7.6%
Hawaiian	189	23.1%
Hispanic, Other	9	1.1%
Japanese	42	5.1%
Korean	1	0.1%
Micronesian	4	0.5%
Mixed	222	27.2%
Pacific Islander	13	1.6%
Portuguese	21	2.6%
Puerto Rican	7	0.9%
Samoan	22	2.7%
Not Available	138	14.5%

Table 4. Diagnostic Distribution of Youth with Authorized Services

Any Diagnosis of	N	%
Disruptive Behavior	470	49.2%
Attentional	381	39.9%
Mood	357	37.4%
Miscellaneous	256	26.8%
None Recorded	184	19.3%
Anxiety	171	17.9%
Substance-Related	154	16.1%
Adjustment	108	11.3%
Deferred	90	9.4%
Mental Retardation	17	1.8%
Pervasive Developmental	4	0.4%

Note: Percentages may sum to more than 100% because youth may receive diagnoses in multiple categories.

Youth registered with CAMHD receive annual diagnostic evaluations using the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994). Children and youth may receive multiple diagnoses on the first two axes of the DSM system. To summarize this information, diagnoses are classified into primary categories and the number of youth receiving any diagnosis in each category is reported (see Table 4). Thus, the reported percentages may exceed 100% because youth might receive diagnoses in multiple categories. The top three diagnoses of youth with

procured services in the quarter were disruptive behavior disorders (49.2%), attentional disorders (39.9%), mood disorders (37.4%). This is a marked change over the previous quarter when the diagnostic profile for the top three diagnoses was mood disorders (25.6%), disruptive behavior disorders (25.3%) and attentional disorders (22.1%). Although the top three disorders remained the same as previous quarters, the ordering and overall population of youth receiving these diagnoses was higher.

This increase likely reflects a deliberate effort on the part of the FGCs to update diagnostic information. Three factors in particular may relate to this increase: (a) the end of the academic year may contribute to a concerted effort and time to complete outstanding annual evaluations, (b) FGCs are increasingly using the clinical reporting module so they receive routine feedback about the current diagnostic status of youth, and (c) the new SEBD referral process includes examination of youth's diagnostic status. The higher proportions also demonstrate that the current youth served by CAMHD typically exhibit multiple, complex behavioral issues.

Services

The tracking and analysis of services that are provided is a vital function in any service system for a number of reasons. Tracking of utilization of the services within the CAMHD array allows for accurate accounting and data-driven planning and decision-making. Service utilization information is used throughout CAMHD to assure efficient use and timely access to services. On the case level, service data are constantly reviewed to provide services based on child and family needs and within the least restrictive environment.

CAMHD tracks the utilization of services through CAMHMIS for services that are electronically procured. For services that are not electronically procured, information from the Clinical Services database is used to augment the CAMHMIS database to yield the final numbers reported here. CAMHD produces a detailed quarterly service utilization report with information regarding statewide utilization of services for all levels of care. As discussed previously, because utilization data are dependent on an accounting of claims adjudicated it is not possible to present actual utilization for the reporting quarter (January-March 2003). Therefore, service authorization data are presented here which closely approximates the actual utilization for the quarter for most levels of care.

During the quarter, the largest percentages of youth served were authorized to receive either Intensive In-home services (46.1%) or Multisystemic Therapy (19.4%). The largest group of youth in an out-of-home setting received services in a Community-based Residential program (17%). Youth receiving treatment while in Therapeutic Family Homes accounted for 14.2% of those served, and Therapeutic Group Homes 11.8%. Flex services were provided for 16.4% of youth served. The pattern of relatively few families receiving Respite services continued with only 2.7% of the served population accessing this service in the reporting quarter.

Table 5. Service Authorization Summary (April 1, 2003-June 30, 2003).

Any Authorization of Services	Monthly Average	Total N	% of Registered	% of Served
Out-of-State	7	7	0.4%	0.7%
Hospital Residential	17	27	1.5%	2.8%
Community High Risk	8	9	0.5%	0.9%
Community Residential	122	162	9.0%	17.0%
Therapeutic Group Home	83	113	6.3%	11.8%
Therapeutic Family Home	119	136	7.6%	14.2%
Respite Home	1	2	0.1%	0.2%
Intensive Day Stabilization	2	5	0.3%	0.5%
Multisystemic Therapy	136	185	10.3%	19.4%
Intensive In-Home	343	440	24.5%	46.1%
Flex	98	157	8.8%	16.4%
Respite	21	26	1.4%	2.7%
Less Intensive	8	18	1.0%	1.9%
Crisis Stabilization	3	8	0.4%	0.8%

Note: Youth may receive more than one service per month and not all youth will have a service procured each month, so the percentages may add to more or less than 100%. The monthly average to total census ratio is an indication of youth turnover with a high percentage indicating high stability.

Cost

CAMHD uses several sources to produce information regarding expenditures and the cost of services. Services billed electronically and purchased through the provider network are recorded directly by CAMHMIS when the records are approved for payment (a.k.a. accepted records). Because cost data are available the quarter following the adjudication of all claims, the cost data discussed below represents expenditures for services provided during the third quarter of fiscal year 2003 (January 1, 2003-March 31, 2003). Unit cost information may not be available in CAMHMIS for certain types of services or payment arrangements (e.g., cost reimbursement contracts, emergency services). For these services, wherever possible, service authorizations are used to allocate the cost of services (e.g., Flex, Mokihana, Multisystemic Therapy, Out-of-State, Respite) to specific youth and Family Guidance Centers.

Detailed allocation of cost information for the reporting quarter by each level of care is presented in Table 6. Out-of home residential treatment services in Hawaii, including hospital-based residential treatment accounted for 81.9% of expenditures. This compares to out-of home service accounting for 84% of the total costs in the second quarter or a 2.1% decrease in percentage of total expenditures. Youth in out-of-state treatment settings accounted for only 1.5% of total expenditure, the same as the previous quarter. The total cost and cost per youth in this category increased slightly over the previous quarter reflecting that these youth also received some services at other levels of care.

Table 6. Cost of Services

Any Receipt of Services	Total Cost ($)	Cost per Youth ($)[a]	Cost per LOC ($)[b]	% of LOC Total ($)[b]
Out-of-State	309,048	44,150	135,891	1.5%
Hospital Residential	1,032,715	32,272	706,875	7.7%
Community High Risk	488,634	40,720	440,550	4.8%
Community Residential	3,674,993	24,178	3,184,576	34.7%
Therapeutic Group Home	2,139,097	21,391	1,634,890	17.8%
Therapeutic Family Home	1,924,897	14,258	1,547,788	16.9%
Respite Home	3,330	3,330	880	0.01%
Intensive Day Stabilization	18,445	6,148	5,500	0.1%
Multisystemic Therapy	772,815	4,336	556,416	6.2%
Intensive In-Home	1,470599	3,820	640.720	7.0%
Flex	3,508.376	20,883	279,713	3.0%
Respite	50,260	2,285	10,982	0.1%
Less Intensive	245,409	18,878	13,017	0.1%

Note: [a] Cost per youth represents the total cost for all services during the period allocated to level of care based on duplicated youth counts. Thus, the average out-of-state cost per youth includes total expenditures for youth who received any out-of-state service. If youth received multiple services, the total expenditures for that youth are represented at multiple levels of care. [b] Cost per LOC represents unduplicated cost for services at the specified level of care.

Both Hospital-based Residential Services and Community-based Residential Services experienced decreased cost. Youth with high-risk sexualized behaviors who received treatment services in a Community High-Risk Program at some point during the quarter had the second highest total cost per youth ($40,720 per youth). For other types of residential treatment, the lowest cost per youth was for those who received services in

Therapeutic Foster Homes ($14,258). Outside of costs for youth in out-of state settings, this data is fairly comparable to the second quarter data presented in the last report.

In-home (Intensive In-home and MST) and less intensive services accounted for 13.3% of the unduplicated cost of services, which was slightly higher than the second quarter percentage of total costs for those categories. Youth receiving Intensive In-home services at some point during the quarter cost an average of $3,820 per youth, which continues to be significantly less than the cost per any youth in a residential program. Due to manual billings for youth who receive in excess of the Performance Standard for this service, this number is an underestimate of the true cost for youth at this level of care. Youth who received Flex services during the quarter had a cost of $20,883 per youth. Flex services may include out-of home services for some youth. The average cost per youth for a child receiving Flex at some point during the quarter also includes their service costs in other levels of care.

Comprehensive information on expenditures beyond the services tracked by CAMHMIS is obtained through the Department of Accounting and General Service's Financial Accounting Management Information System (FAMIS). For this report, FAMIS provided information regarding total general fund expenditures and encumbrances for central office and family guidance centers that are reported in the Performance Measures section. However, it is important to note that FAMIS tracks payments and encumbrances when they are processed at the Departmental level. Due to the time lag between service provision and payment, the CAMHMIS and FAMIS systems do not track the same dollars within any given period. Therefore, estimates provided here are used for general guidance, and detailed analysis is conducted by CAMHD Administrative Services.

Services for Youth With Developmental Disabilities

CAMHD entered into a Memorandum of Agreement (MOA) with the Developmental Disabilities Division (DDD) of the Department of Health in July 2002 for the purposes of serving the needs of those youth with mental retardation and/or developmental disabilities who had previously received respite and out-of-home services through CAMHD. The MOA transferred funding and personnel to DDD in order to provide youth with the most appropriate individualized supports consistent with national best practices in developmental disabilities. An MOA between CAMHD and DDD for fiscal year 2004 to continue the provision of services, supports and coordination for these youth has been executed.

During the fourth quarter CAMHD conducted monitoring of the provision of services and expenditures of funds by DDD for youth identified in the MOA. The fiscal review included a verification of expenditures for residential services, respite services, and personnel costs. Programmatic monitoring consisted of case record reviews and individual case-based reviews, which included records reviews, interviews with administration, case workers, and parents.

Fiscal Review Findings

A total of $2,416,310 was transferred to DDD for the provision of respite and residential services. This total also includes personnel costs for transferred positions. (Note: This data was reported in the last quarter's report as exclusive of funding for personnel costs). Of this amount DDD budgeted $362,000 for respite. For fiscal year 2003, $316,785 was expended.

To provide residential services, DDD entered into a contract with Child and Family Services for $1.2 million. Subsequently, the contract was modified and increased to $1,454,006. Through May 2003, $1,223,688 was expended including some funds expended prior to the execution of the service contract. Table 6 displays the Fiscal Year 2003 expenditures of DDD MOA funds.

Table 7. DDD MOA Fiscal Year 2003 Expenditures

Category	Per MOA	Actual	Difference
Residential Services	1,671,442	1,478,841	192,601
Respite	362,000	316,855	45,145
Personnel (7 positions)	339,868	226,729	113,139
Personnel related	43,000	Note 1	Note 1
Other:			
Kapiolani Medical Specialists	0	24,500	(24,500)
Total Funds	2,416,310	2,046,925	326,3855

Note 1: The actual personnel related costs could not be determined as they are not isolated from other DDD costs

Respite Services

The population eligible to receive respite services in the MOA was originally identified at 205 youth. Eligibility for the original target population was defined as having documentation of need, or utilization of respite services through CAMHD. Eight additional youth were identified as eligible through informational meetings that were subsequently held. Following the transfer of responsibilities for the administration of these funds, DDD further looked for the documentation to support the need. Of the original 205 youth, 117 families or 56% were identified by DDD as eligible and in a position to receive respite supports. Explanation of the numbers of youth determined eligible to receive the service is found in the previous quarter's report.

The funding transferred to DDD for respite services was $362,000. DDD tracks respite expenses by client by month and reports spending $316,855 for July 02 through Jun 03. The amount is reconcilable with the check register report from Computrust, the company that issues the checks. The unused amount from the transferred funds was $45,145.

Data indicate that the largest percentage of respite funds is used to serve the largest target population for youth, on the island of O'ahu. Expenditures by island also indicate that Kauai has the highest respite expenditures for the fewest number of youth (11), with respite reimbursements ranging from $500.00 to $9,216.00 per child. An increase in the expenditure of respite funds was noted in the 4th quarter as evidenced by an increase in the spending from $89,419.75 in the 3rd quarter to $123,749 in the 4th quarter.

Residential Services

DDD contracted with Child and Family Service (CFS) for Individualized Community Residential Supports (ICRS) at an original amount of $1,200,000 for the period July 8, 2002 through June 30, 2003. The funding amount of $1.2 million initially included an administrative cost of 25% and a daily rate of $190.00/day. The contract was subsequently modified on May 6, 2003 and increased to $1,454,006. The revised contract amount was negotiated between CFS and DDD. The increase was primarily due to the need to place one client in a Hospital-Based Residential (HBR) program at a cost of $625 per day. For the first seven days of July 2002, there was a separate purchase order with CFS for $24,835 resulting in the total year expenditure of $1,478,841 with CFS. Through May 2003, CFS reported expenditures totaling $1,223,688. The June report was not available at the time of this writing. The funding transferred to DDD for residential services was $1,671,442, meaning that $192,601 was unused. For FY04, the CFS contract amount will be $986,390.

The number of clients originally identified in the MOA was 12. One more client was subsequently identified and added to the program. Of the 13, two have aged out and are no longer served under the contract. Ten out of the eleven active youth receiving community-based residential services have also been admitted to the waiver program. Services offered under the waiver include personal assistance, habilitation, habilitation supported employment, respite, skilled nursing, environmental adaptation, transportation, specialized services and adult day health.

The contract budget of $1,454,006 includes $532,057 in administrative cost, $665,907 in service cost, and $256,042 for the client placed in the HBR program. The administrative cost represents 37% of the budget. CFS provides monthly reports to DDD showing service costs for each client. For the period July 2002 through June 2003, these totaled $1,001,324, including $240,125 for the child receiving HBR services. The amounts spent range from a low of 0 for two clients to a high of $223,433 for another (not counting the child in the HBR program). Based on these reports from CFS, this would mean an actual administrative cost of $452,682 (31% of the total), assuming that CFS spends the entire budget.

Using thirteen clients as the denominator, the total per client cost in FY03 was $113,757.

Personnel

The funding transferred to DDD included $339,868 for seven positions as well as $43,000 in personnel related costs. DDD provided a report showing the July 2002 through June 2003 payroll expenses for the seven positions. Two of the positions were vacant all year while three others were filled for about half the year. The two specialist positions that were filled for most of the year are now vacant. The funding for one of the positions is being used to pay for the services provided by Kapiolani Medical Specialists, which cost $24,500 for three months ending June 2003, and a Maui developmental pediatrician. The funding for the other specialist position is currently not allocated, as the vacant positions is being recruited for. The total payroll expense for the seven positions was $226,729 meaning that $113,139 of the MOA funds transferred was unused. For FY03, DDD commented that caseloads for the transferred positions may not have been exclusively for the CAMHD clients. Other personnel related costs could not be determined as they are mixed in with DDD expenses.

Program Review Findings

Respite Services

Based on DDD data, of the 132 families (126 families plus six added since April 2003) described above as eligible to receive respite, 95% have received the service. Seven families have not received respite reimbursements. DDD reports efforts by case managers to contact these seven families and has sent certified letters to families regarding the available service.

To date, twenty-three of the youth receiving respite, who were connected with the DDD through the MOA have been admitted to the Home and Community Based Services Waiver (HCBS-DD/MR) as they meet level of care and Medicaid eligibility. Fifty of the youth deferred admission to HCBS Waiver. The remaining 59 youth have a variety of reasons for not choosing waiver or the deferral option at this time. Reasons included: family was not interested, case was closed with family consent, family utilized DDD respite, family utilized Partnerships in Community Living (PICL) funds, family was Medicaid ineligible, family is in process of applying for waiver, family is unresponsive to case manager calls, youth has a skills trainer through DOE, and family is requesting reassessment of youth's eligibility with DDD.

Fourteen records and one individual case were reviewed in order to confirm how families access respite at the program level including access to respite funds. As well, an intensive case-based review was conducted to examine child status as related to the adequacy of key programmatic functions.

The review found that overall, DDD case managers have communicated with families regarding access to respite funds, PICL funds, and waiver services. Case managers were consistent with documentation of contact with families. Documentation, however, was limited to recording that contact was made. It did not generally describe the current status of the youth and family, nor the impact of services on achievement of behavioral and educational objectives.

The case-based review found the youth to be making progress, and behavioral concerns are adequately addressed. Team members are employing functional analysis to determine root causes. The parent reported difficulty with accessing support including respite and case management services, causing the parent to feel under supported in the parental role. Respite supports were reported to have decreased over the year. Satisfaction was rated to be unacceptable. Overall findings were minimally acceptable as the provision of "seamless," well coordinated services across settings has not been fully addressed by the child's service team.

A key recommendation as a result of the review of respite service provision is to assure coordination of services for youth with severe behavioral challenges due to co-occurring developmental and mental health issues. These coordination functions would benefit from further training of case managers on the Department of Education processes, working within multi-agency teams, accessing treatment and intervention resources, and increasing family engagement skills. Case management documentation should also record information related to child and family improvements and progress on individualized goals, which was notably weak in the review of records. Families would also likely benefit from further specific education regarding how to access respite funds. An additional recommendation based on review findings is to engage in formal discussions with the Department of Education related to partnerships around planning and service provision with the goal of streamlining access to supports and community resources, reducing gaps in service, and facilitating effective transitions for the population.

Residential Services

Seven (7) of the 13 youth, or 54% of the target population, are served on the island of O'ahu, 5 youth, or 38%, on Hawaii, and 1 youth, or 8%, on Maui. Since April 2003, the majority of the youth were living in a foster home (4 of 13), three (3) in a special treatment facility, one (1) is currently in a respite home, one (1) in a hospital-based residential setting, one (1) in an independent living home, one (1) returned to the natural family, a second youth (who has aged out) returned to the natural family, and one (1) (who has aged out) is living independently in a boarding home situation.

Out of the 11 youth currently being served, 7 have remained in the same placement since the execution of the ICRS contract on July 1, 2002. Changes in placement occurred for the remaining 4 youth. Placement changes ranged from one to five times for the four youth and occurred for a variety of reasons including loss of foster placement, need for heightened supervision, and parental request for change in placement. The average number of placements for the 11 youth is 1.81 placements since the execution of the ICRS contract. The range of services offered in the various residential programs include room and board, supervision, coordination/linkage with DDD, DOE, and families, skills trainers, individual therapy, medication management and nutritional consultation and oversight.

Case management services are provided to the 13 (11 youth +2 adults) through DDD. In addition, case managers have admitted eligible individuals to the Home and Community Based Services-DD/MR Waiver (HCBS - DD/MR) who meet

level of care and Medicaid eligibility. Out of the 13 youth served in the contract, 9, or 70%, have been admitted to the waiver. The average amount of hours of waiver supports per youth per week is currently 86 hours.

A sample of youth receiving residential services was reviewed through a case-based protocol. The service review examined their status across indicators of well-being and the adequacy of key program functions. All of the youth reviewed were found to have both acceptable child status and acceptable system performance. Overall, the children reviewed were doing well, were making academic progress consistent with there abilities, were in the least restrictive living and learning environments, and were found to be emotionally well. System performance indicators describe and measure how the overall system, including team members, is able to provide services and supports required by youth and families. Indicators are grouped under four broad areas: Understanding of the Situation, Planning of Supports and Services, Implementation, and Finding What Works. Individual indicators address understanding the youth and families needs, preferences, and successful interventions, adequate and comprehensive planning, timely implementation, and achievement of desired results. Three of the four broad areas received acceptable ratings for all of the youth reviewed. Reviewers found that case managers, treatment team members, and service providers consistently possessed a comprehensive base understanding of the youth's situation, needs, and capacities. All of the youth reviewed had adequate functional assessments, a functioning and cohesive service team, and family participation in the assessment process. However, planning processes and adequacy of treatment plans were found to need improvement for the youth reviewed.

Case managers were interviewed as a part of the review process. Several identified the need for further skills and support in their role with DD youth with severe behavioral issues, particularly with those who are sexually reactive or have co-occurring mental health disorders. Case managers have experienced particular difficulty partnering with personnel in the schools.

Recommendations include: 1) Joint training and mentoring between DDD and CAMHD to build skill in case management and service provision for youth with developmental disabilities and co-occurring mental health issues, 2) Training of DDD case managers regarding Department of Education processes, working within multi-agency teams, accessing treatment and intervention resources, and increasing engagement skills, and 3) Identify needed support services for caregivers of youth in out of home settings.

Overall Supports for the Population

The CAMHD-DDD MOA moved positions and funds to DDD to provide services to the eligible population. Included were positions to provide planning, consultation and supports for youth with Pervasive Developmental Disabilities. Assessment of the needs of the population has resulted in an agreement with the DDD and Kapiolani Medical Center. The Agreement of Services, began on April 1, 2003, commences collaboration to accomplish the following: 1) Define health outcomes for individuals with developmental disabilities/mental

retardation including assisting in community discussions on the definition of health outcomes for individuals with DD/MR and providing independent consultation on particular issues of health and well being as raised by advocacy agencies; 2) Provide opportunities for the development of a "medical home" concept for individuals with DD/MR including consultation and education/training by DOH/DDD case managers and medical students from the John A. Burns School of Medicine and Consultation with parents and individuals with DD/MR, particularly to address transition issues; 3) Provide consultation to DOH-DDD staff statewide on medical/health issues facing individuals with DD/MR throughout the life span; and 4) Provide consultation to community physicians on individuals with DD/MR - e.g., provide a developmental clinic for individuals with DD/MR, particularly those with "dual" diagnosis and on polypharmacy. DDD is also addressing consultative and service relationships with a developmental pediatrician on Maui and autism specialists targeted at enhancing and sustaining its statewide capacity.

DDD is developing a quality assurance system that will use information to trigger immediate action for health and safety concerns, as well as update the Division's strategic plan priorities, goals, activities and allocation of resources. The CAMHD Chief and DDD Chief will develop cross-training opportunities regarding case management.

Performance Measures

As discussed earlier, CAMHD's performance measures gauge sustainability of services and results, and for demonstrating the adequacy of services, infrastructure, and key practice initiatives at the level needed to maintain gains that have been made since the inception of the Felix Consent Decree and achieve CAMHD practice standards. CAMHD has set performance goals for each measure. If baseline performance falls below the established goals, CAMHD systematically examines the trends and any barriers, and develops strategies to achieve each goal. A stable pattern of results (i.e., a flat line) indicates that CAMHD is sustaining performance at baseline levels. A line that exceeds its benchmark indicates that CAMHD has surpassed its performance goals.

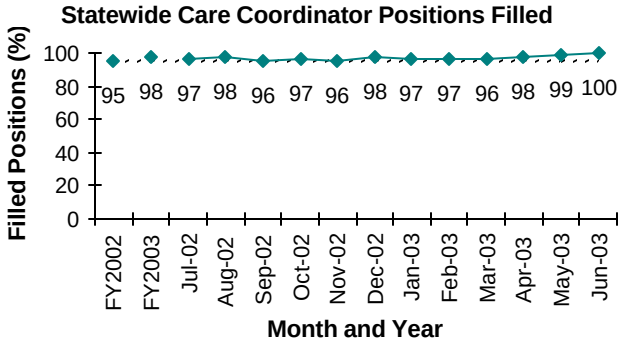
Those performance measures linked to previous Court Benchmarks are noted by an asterisk (*).

CAMHD will maintain sufficient personnel to serve the eligible population.

Goal:

⇨ 95% of mental health care coordinator positions are filled*

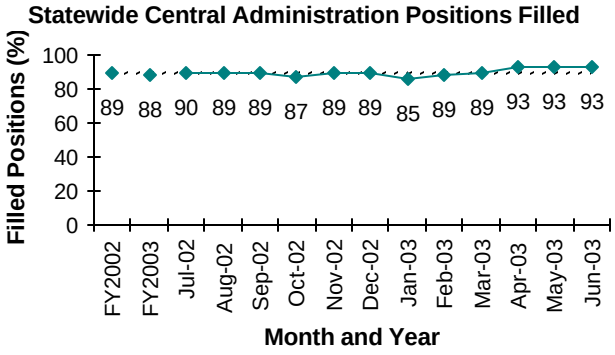
Over the reporting period, an average of 99% of care coordinator positions statewide were filled, exceeding the goal. At the end of the reporting period (June 2003), all Family Guidance Centers had 100% of positions filled. The trending of this indicator measures the capacity of the Family Guidance Centers to provide intensive case management services for children and families. There has been stability in this measure throughout the year.



Goal:

⇨ 90% of central administration positions are filled*

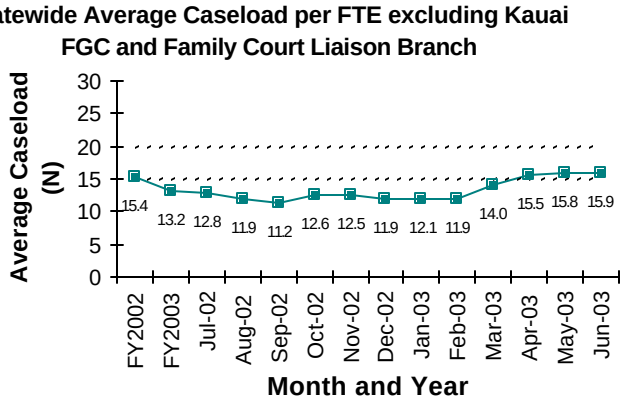
The performance target was met with an average of 93% of central administration positions filled over the quarter. Central administration positions provide the infrastructure and quality management functions necessary to manage the statewide service system. Vacancies were experienced primarily in the Performance Management Office, but these positions are expected to be approved soon for hire.



Goal:

⇨ *Average mental health care coordinator caseloads are in the range of 15 - 20 youth per full time care coordinator.*

CAMHD has continued to develop its thinking about how best to monitor care coordinator caseloads throughout the state. Historically, average caseloads have been used for this measure. CAMHD has been exploring the possibility of calculating the percent of care coordinators with caseloads within the range in an effort to represent the equity of caseload distribution in addition to average size. CAMHD has decided to continue using the historical indicator of the average and to examine the caseload distribution across centers rather than individuals. CAMHD expects that care coordinator caseloads fall in the range of 15 to 20 youth per full time care coordinator.



The average caseload for the fourth quarter was within the target range at 15.7 youth per full time care coordinator equivalent (FTE). The majority of the FGCs were in the target range although some variability was evident across centers. This calculation of average excludes Kauai, who serve both high-end and low-end youth through

Average Caseloads by Family Guidance Center

	COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC
4th Quarter Average	17	17	15	14	15	16

the Mokihana project and therefore tend have higher caseloads. Family Court Liaison Branch is also excluded because staff tend to provide direct services to youth who are either receiving care coordination from another family guidance center or are being served at Detention Home or Hawaii Youth Correctional Facility.

CAMHD will maintain sufficient fiscal allocation to sustain service delivery and system oversight.

Goal:

⇨ Sustain within quarterly budget allocation

As seen below, in the reporting quarter, the total variance from the budget was under projection by $16,915,000. As such CAMHD sustained significantly below the budget allocation in the quarter. CAMHD has expended within its budget allocation for all quarters this fiscal year. The lower costs have resulted a smaller registered population, lower utilization of very high-end services (i.e., out-of-state and hospital-based residential), and implementation of performance standards and practice guidelines.

Variance from Budget (in $1,000's)

	FY 2002 Average	FY 2003 Average	2002.1	2002.2	2002.3	2002.4	2003.1	2003.2	2003.3
Branch Total	$164	-$147	$82	$153	$290	$130	$66	-$195	-$312
Services Total	$798	-$5,311	$1,487	-$84	$501	$1,287	$315	$2	-$16,251
Central Office Total	-$189	-$467	-$254	$59	-$535	-$25	-$833	-$216	-$352
Grand Total	$773	-$5,925	$1,315	$128	$256	$1,392	-$452	-$408	-$16,915

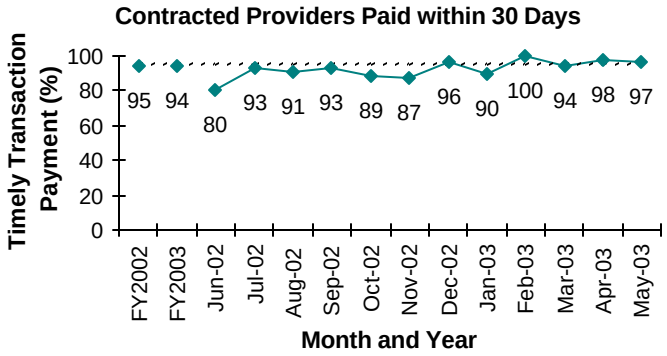
Note: Includes $3,475,000 encumbered in March for Kalihi in FAMIS, but shown here in Other

CAMHD will maintain timely payment to provider agencies

Goal:

⇨ 95% of contracted providers are paid within 30 days

The target goal was achieved with an average of 97.5% of payments timely over the two months with available data. Performance on this measure has been fluctuating around the target range with the year-to-date average remaining slightly below the benchmark. The period ended with the strongest performance of the fiscal year.

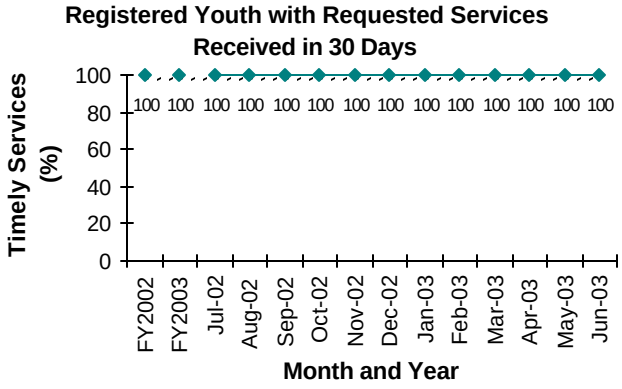


CAMHD will provide timely access to a full array of community-based services

Goal:

⇨ 98% of youth receive services within thirty days of request*

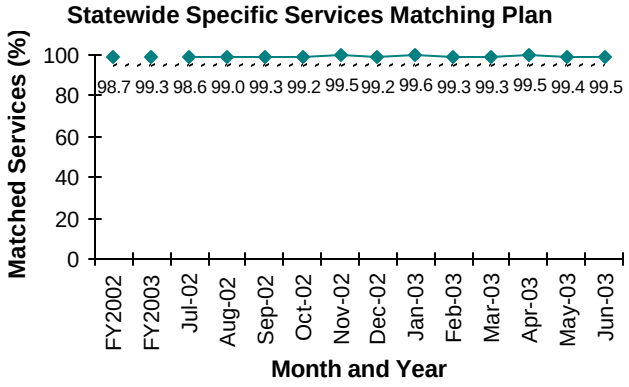
The goal was met for the quarter with 100% of youth receiving services provided timely access to those services. The last reported service gap was in August of 2001.



Goal:

⇨ 95% of youth receive the specific services identified by the educational team plan*

CAMHD continued to demonstrate strong performance on this measure. Over 99% of youth in the quarter received the specific services identified by their team plan. In the third quarter, service mismatches occurred in eleven complexes. These youth received services within 30 days, but they were not the exact service prescribed by their IEP teams. Of the eleven complexes, two complexes had three or greater mismatches (Baldwin had six and Konawaena had three). The remaining nine complexes had two or fewer mismatches. There were no significant patterns in service mismatches over the third and fourth quarters. Baldwin Complex's mismatches were mainly due to shortage of intensive in-home providers on Maui, which is being addressed through recruitment by the provider agency. Konawaena's service mismatches have been addressed as those youth now are in the programs identified in their plans. During the interim they were receiving services, two in higher levels of care, and one through SBBH.

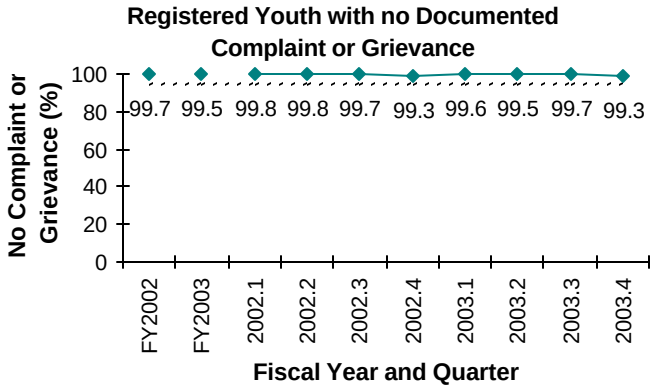


CAMHD will timely and effectively respond to stakeholders' concerns

Goal:

⇨ 95% of youth served have no documented complaint received*

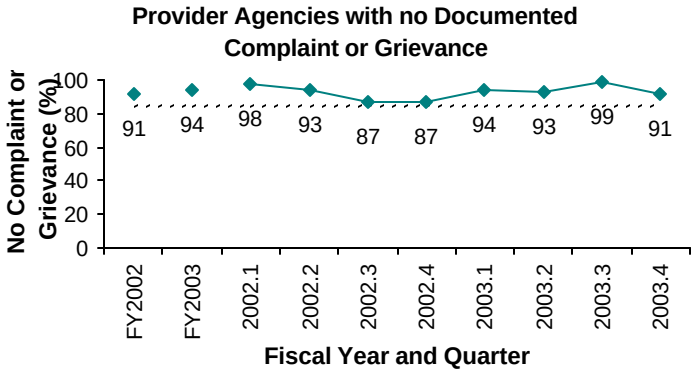
99.3% of youth served in the quarter had no documented complaint received. The target was met across all Family Guidance Centers. There were 12 youth with documented complaints representing eleven complexes: Keeau, Kapaa, Campbell, Kealakehe, King K., Hilo, Castle, McKinley, Pearl City, Kohala and Honokaa. Keeau was the only complex with two complaints represented.



Goal:

⇨ 85% of provider agencies have no documented complaint received*

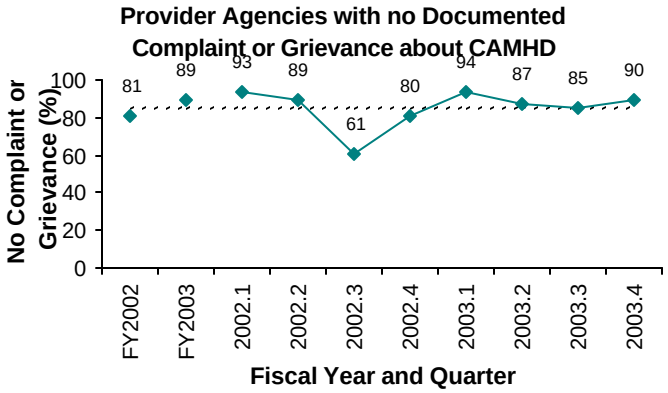
91% of provider agencies had no documented complaint about their services, which exceeded the goal. The fiscal year average was 94% of agencies with no documented complaint about services.



Goal:

⇨ 85% of provider agencies will have no documented complaint about CAMHD performance*

In the quarter, 90% of agencies in the CAMHD provider network had no documented complaint or grievance about CAMHD, which met the goal for this measure. The fiscal year average was 89% of provider agencies with no documented complaint about CAMHD performance. As compared to fiscal year 2002, this indicator has remained above benchmark for the active fiscal year.

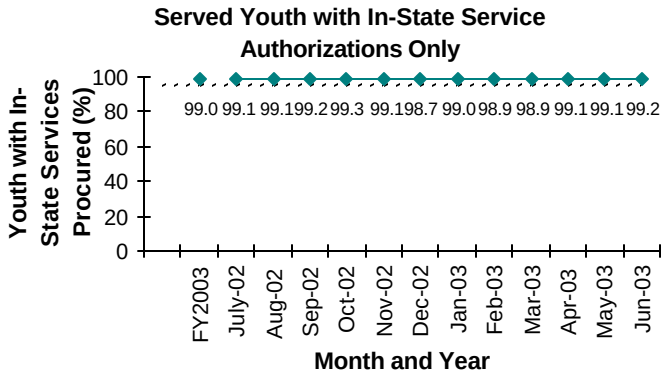


Youth will receive the necessary treatment services in a community-based environment within the least restrictive setting.

Goal:

⇨ 95% of youth receive treatment within the State of Hawaii*

In the quarter, an average of 99% of youth served received treatment within the State, which exceeds the goal. This trend has remained stable over the past year. Only six youth are receiving services in out-of state treatment settings.

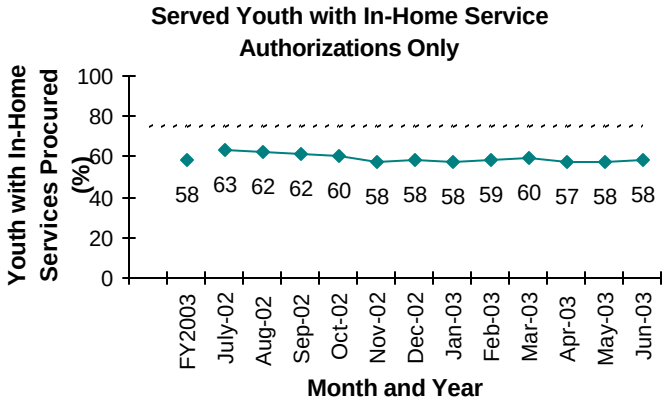


Goal:

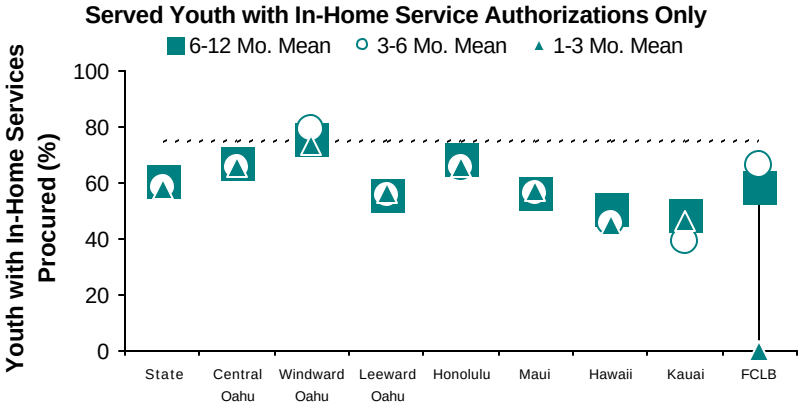
⇨ 75% of youth are able to receive treatment while living in their home

The baseline trend for youth receiving services while living in their homes averaged 58% of the CAMHD population throughout FY 2003. Because the 75% benchmark was set based on historical data, when CAMHD also served youth with less intensive needs, evaluation of the performance goal is indicating that an adjustment to this benchmark is needed to more realistically align with the service utilization patterns of youth with intensive needs. It is also important to note that the methodology for this indicator measures youth who have received services in an out-of home setting at any time during the quarter. Therefore, although 58% of youth with a service authorization in the reporting quarter received treatment while living at home, 42% received a service authorization for treatment out-of home at some point in the quarter.

The indicator is not sensitive to shorter lengths of stay for youth in out of home treatment settings. For example, census data derived from point in time reporting is indicating a downward trend for youth in out-of-home settings, indicating less youth overall out-of-home on any given day in the month. These data indicate that progress is evident by the Family Guidance Centers in reducing out-of home time for youth through consistent clinical review of utilization of any youth receiving treatment in an out-of home setting. Although there have been some minor fluctuations in the measure over the year, the period ended at the year to date average.



As in past quarters, there was variability in the measure across communities in the reporting quarter. Seen below, the trend in each of these areas has been fairly stable since last July, indicating contextual issues are likely impacting the measure in each community.



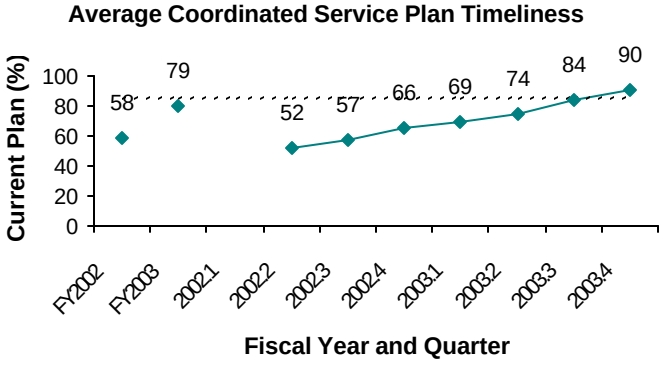
Note: Because FCLB provides many direct services rather than procuring services, these proportions are expected to have greater variability and the mean levels are not directly comparable to the other centers.

CAMHD will consistently implement an individualized, child and family centered planning process

Goal:

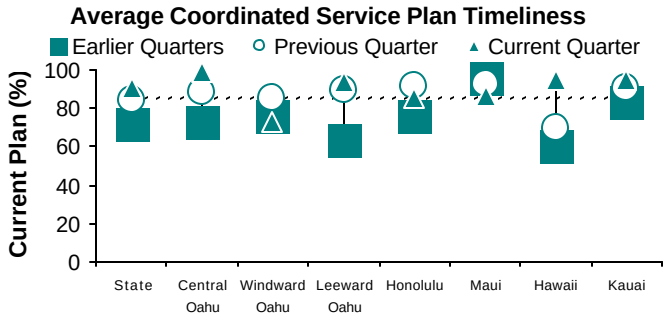
⇨ 85% of youth have a current Coordinated Service Plan (CSP)*

CAMHD's performance in this measure met the performance goal. for the reporting quarter as 90% of youth across the state had a current CSP. Current is defined as having been reviewed at a minimum within the last quarter and adjusted or revised to reflect the child's current situation as often as necessary. The strong upward trend in this measure represents concerted efforts by teams to assure a service plan for each youth.



Note: This data includes youth who were newly admitted to CAMHD who have not yet had a CSP developed

Every Family Guidance Center with the exception of the Windward Family Guidance Center met the performance goal during the quarter. Teams on the Big Island made the largest gains in CSP timeliness. The focused improvements discussed in last quarter's report are reflected in their improved data in this measure. Windward's management team has looked carefully at the factors impacting plan timeliness and has implemented measures to assure close supervision through better ongoing tracking of progress. They are instituting management controls that are targeted at addressing timeliness issues.

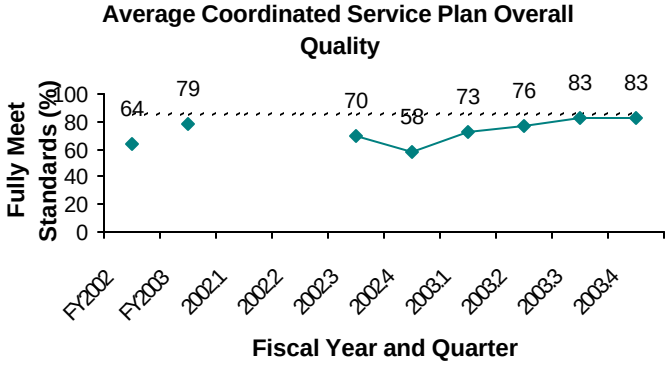


Goal:

⇨ 85% of Coordinated Service Plan review indicators meet quality standards*

Reviews of CSPs against quality standards are conducted quarterly in each FGC. In order for a CSP to be deemed as acceptable overall, there must be evidence that the plan is meeting key quality indicators including stakeholder involvement, a clear understanding of what the child needs, individualization of strategies, identification of informal supports, long-term view, plan accountability, use of evidence-based interventions, crisis plans and other key measures.

The goal for this measure fell just short of being met in the reporting quarter with 83% of CSPs sampled meeting overall standards for quality. Based on this positive performance trend, quality is projected to continue to improve in the next quarter.



There have been improvements or sustainability of efforts in facilitating plans that meet quality standards in the quarter across most of the Family Guidance Centers. Central, Maui, Kauai and the Big Island are fully meeting standards at levels above performance goals.

Mental Health Services will be provided by an array of quality provider agencies

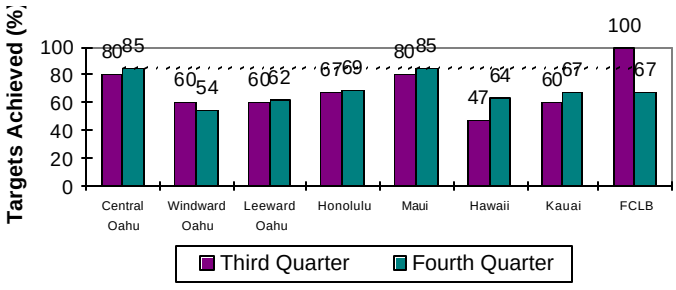
Goal:

⇨ 85% of performance indicators are met for each Family Guidance Center

Family Guidance Center performance is evaluated based on the percentage of performance targets that are met or exceeded in the quarter. Performance targets are comprised of the relevant measures presented in this report, and include individual FGC performance on: expenditures within budget, complaints, access to services, least restrictive environment, timeliness and quality of coordinated service plans, performance on internal reviews, and improvements in child status.

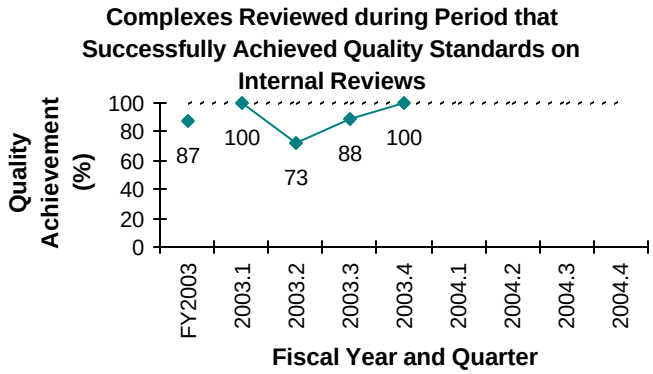
The goal of meeting 85% of the performance indicators was met by Central and Maui FGCs. This is the first quarter to date that all goals have been met by one or more FGCs. There were improvements in meeting all goals in six of the eight FGCs as seen below. On average across all FGCs, 68% of all goals were met in the fourth quarter as compared to 69% in the last quarter, and 55% in the first quarter. Any performance goals not met by a Family Guidance Center are being addressed through specific improvement strategies, which the FGC management team will track for implementation.

FGC Performance Indicators Successfully Achieved



Goal:

⇨ 100% of complexes will maintain acceptable scoring on internal reviews*



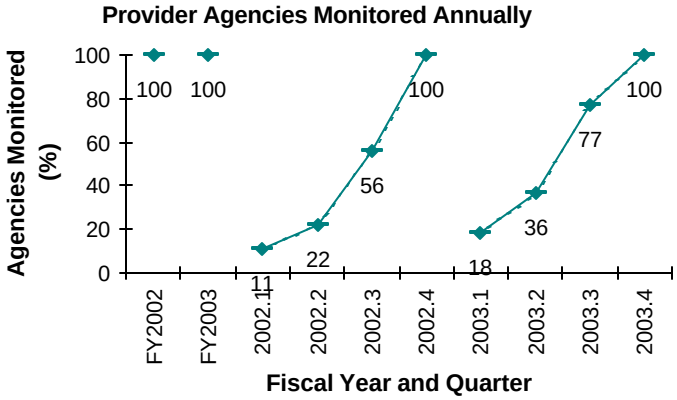
Acceptable scoring continues to be defined as achieving acceptable system performance for 85% of cases reviewed. The performance target, which is a joint DOE-DOH measure, is for all complexes to achieve the goal. In the quarter, only Waiakea Complex was reviewed, and the goal was achieved. The statewide trend is displayed above. During the year 87% of complexes achieved the performance goal of acceptable system performance at 85% or better system performance.

Mental Health Services will be provided by an array of quality provider agencies

Goal:

⇨ 100% of provider agencies are monitored annually

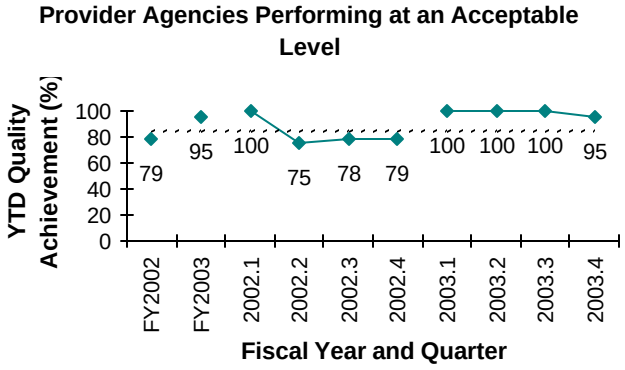
The CAMHD Performance Management Section conducts comprehensive monitoring of all agencies contracted to provide mental health services. Programmatic reviews, including case-base reviews, allow for a focused examination of safe and effective practices. In the fiscal year 2003, 100 % of all agencies contracted to provide direct mental health services were monitored.



Goal:

⇨ 85% of provider agencies are rated as performing at an acceptable level

In the reporting quarter, 95% of the provider agencies reviewed were found to be performing at an acceptable level, meeting the goal for this measure. Provider agencies are reviewed across multiple dimensions of quality and effective practices.

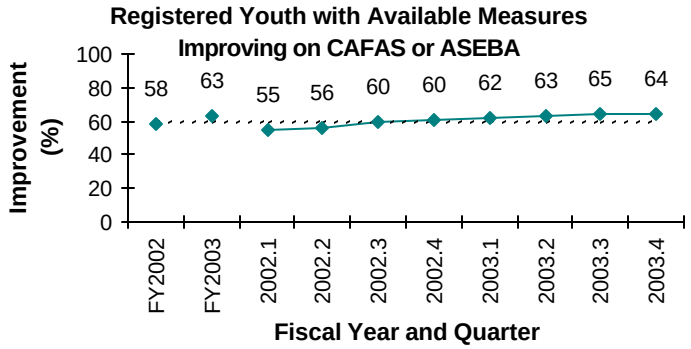


CAMHD will demonstrate improvements in child status

Goal:

⇨ 60% of youth sampled show improvement in functioning since entering CAMHD as measured by the Child and Adolescent Functional Assessment Scale (CAFAS) or Achenbach System for Empirically Based Assessment (ASEBA)*

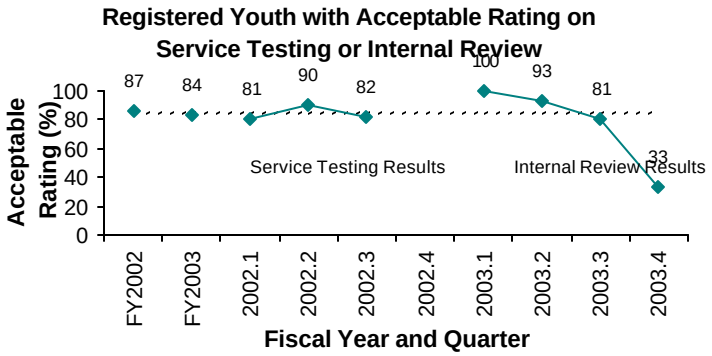
To monitor performance of CAMHD's goal of improving the functioning, competence and behavioral health of youth, care coordinators are required to complete the CAFAS and Achenbach (ASEBA) for each youth. The performance goal is measured as the percentage of youth sampled who show improvements since entering CAMHD services and is set at 60%. In the reporting quarter, for youth with data for these measures, 64% of youth were showing improvements since entering the CAMHD system, which meets the performance goal.



Goal:

⇨ 85% of those with case-based reviews show acceptable child status

In the third quarter, one complex, Waiakea was reviewed. Of the three youth reviewed receiving care coordination through the Hawaii Family Guidance Center, one had acceptable child status and two did not. One of the youth with unacceptable child status also had unacceptable system performance. This child has been referred to the CAMHD Behavioral Specialist for consultation with the FGC clinical team.



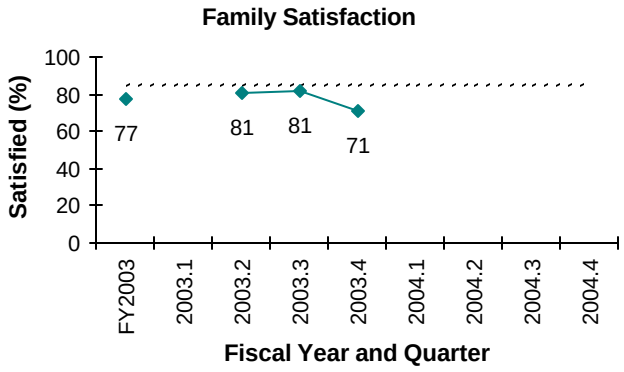
The very small sample size for the current quarter makes this indicator much less reliable. Examination of the broader year to date average of 84% of youth with acceptable child status rating is just short of the performance target. This is comparable to but slightly below the FY 2002 level and suggests relatively stable statewide performance. Whenever a child falls into the unacceptable child status and system performance category, they are referred to the CAMHD Behavioral Specialist for consultation with the FGC clinical team.

Families will be engaged as partners in the planning process

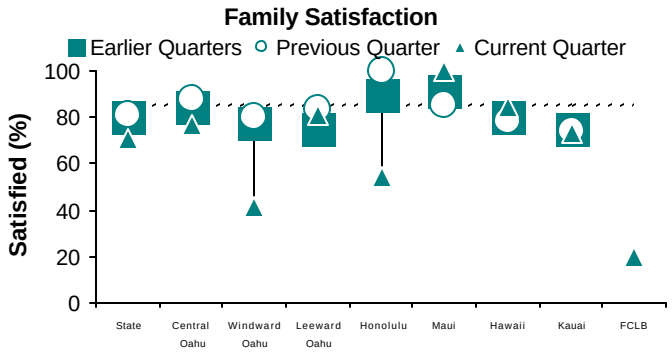
Goal:

⇨ 85% of families surveyed report satisfaction with CAMHD services

Family and youth satisfaction information is collected through the CAMHD family organization partner, Hawaii Families as Allies. This is a significant advancement in the delivery mechanism for obtaining information on consumer satisfaction. As seen, 71% of families surveyed were satisfied with services received in the reporting quarter. This was below performance target for the State, and a departure over the previous quarters' results.



This quarter was the first time youth registered to the Family Court Liaison Branch (FCLB) were included in the sample. As previously noted, youth whose care managed through the FCLB are an expanding population and not likely as comparable to other FGCs. However, when these youth are removed, the statewide satisfaction was still somewhat lower than prior quarters. Specifically, a greater proportion of families indicated "neutral" satisfaction with services in the Windward and Honolulu samples.



It is important to note that the sample sizes for each FGC within each quarter are small, so that these estimates are less reliable and the mean satisfaction across quarters (e.g., the midpoint between the symbols) should provide a somewhat more reliable indicator. Further analysis of these data is summarized in reports to the Performance Improvement Steering Committee (PISC) and are available on the CAMHD website.

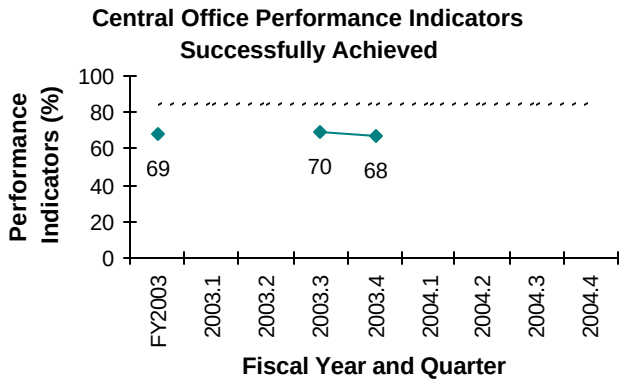
There will be state-level quality performance that ensures effective infrastructure to support the system

Goal:

⇨ 85% of CAMHD Central Office performance measures will be met.

CAMHD's Central Administrative Offices utilize performance measures for each section under the Clinical Services, Performance Management and Administrative Offices as an accountability and planning tool. Central Office measures are approved and tracked by the CAMHD Expanded Executive Management Team, and are reported monthly or quarterly depending on the measure. A total of thirty-five measures are tracked. Performance results and trends are discussed and strategies are developed to sustain or improve performance.

In the reporting quarter, 68% of measures were successfully met which was slightly lower than the baseline in the previous quarter. For each indicator that falls below its performance target, the managers in the respective section examine results. Improvement strategies are established and tracked for implementation. For example, when monitoring reports are not completed within timelines, the performance measure for the Program Monitoring Section, the manager must assess all variables impacting the measure. If solutions require a broader organizational intervention, these are discussed on the regular Expanded Executive Management Team level, and are tracked for implementation.



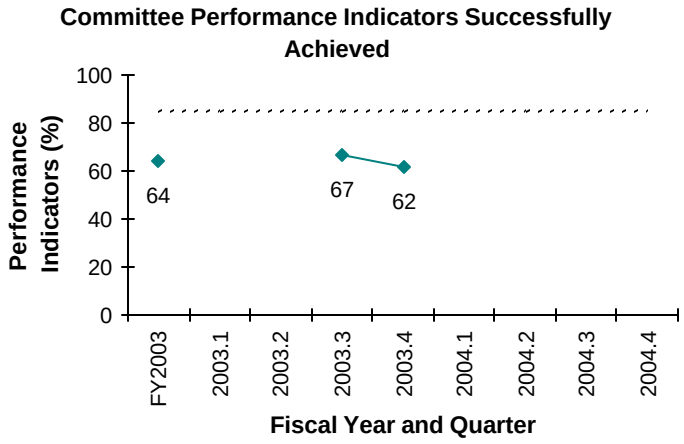
As this is a relatively new performance management system, benchmarks were generally set somewhat above current performance levels to promote quality improvements. Of course, this also causes baseline levels to fall below the performance target and look like less successful performance when aggregated. It should be noted that this represents a functioning quality improvement system, as when benchmarks are continuously achieved over a period of time, measures ideally should be vacated for new performance targets.

Goal:

⇨ 85% of CAMHD State Committees performance measures will be met.

The CAMHD Performance Improvement Steering Committee (PISC) reviews data for its core committees, which include Credentialing, Safety and Risk Management, Grievance and Appeals, Utilization Management, Evidence-based Services, Compliance, Information Systems Design, and Training. A total of thirteen measures are tracked and reported on in the monthly meeting. Similar to Central Office measures, results for each indicator are discussed in the monthly PISC meetings in order to select specific improvement strategies that are implemented by respective CAMHD section managers.

In the quarter 62% of performance goals were met through the work of the CAMHD Committees, which was lower than the baseline measure established in the previous quarter. Most committees are tracking multiple indicators that cross measures of timeliness and quality of committee performance. This quarter's trend will be further examined in the next PISC meeting to determine the need for specific interventions.



Summary

The majority of performance goals were met or exceeded in the fourth quarter. The areas of strength continued to be all measures regarding maintenance of infrastructure, funding, timely access to services, system responsiveness to stakeholder concerns, and quality service provision

The following were measures that met or exceeded goals:

- Filled care coordinator and central office positions*
- Care coordinator caseloads within the range of 1:15-20 youth
- Maintaining services and infrastructure within the quarterly budget allocation
- Contracted providers paid within 30 days
- Youth receiving services within 30 days of request*
- Youth receiving the specific services identified on their plan*
- Timely and effective response to stakeholder concerns* (all performance goals were met)
- Youth receiving treatment within the State of Hawaii*
- Coordinated Service Plan timeliness*
- Central and Maui FGC performance goals
- Complexes reviewed during the period that maintained acceptable scoring on Internal Review*
- Monitoring of provider agencies
- Quality service provision by provider agencies
- Improvements in child status as demonstrated by CAFAS or ASEBA

The indicators newly meeting performance goals were Care Coordinator caseloads within range, Coordinated Service Plan timeliness, Central and Maui FGC meeting goals, and Internal Review performance.

The following measures demonstrated a strong or improving trends, but are not yet achieving the targeted goal:

- Coordinated Service Plan quality*
- Family Guidance Center performance indicators

The most significant gains have been made across the state in assuring current and quality Coordinated Service Plans. Again, the asterisked measures are those linked to demonstration of sustainability of efforts under the Felix Consent Decree process. Of these measures, only one, CSP quality, did not fully meet the performance goal in the fourth quarter, and this indicator has shown improvement during the sustainability period.

The following measures were below-targeted performance:

- Child Status as measured by Internal Review Results
- Family Satisfaction
- Central Office performance indicators

Family satisfaction data are undergoing full analysis for presentation to PISC and will include recommendations for implementing improvement activities that will impact

family satisfaction. Likewise, all indicators used to impact performance at the Central Office are routinely examined at PISC and by management to develop actions that will impact the trends.

There was one measure that demonstrated stable performance but continued to be below benchmark. This measure is:

- Youth receiving treatment while living in their homes

As discussed in the last Sustainability Report systematic clinical review is occurring in each FGC to assure that out of home services are used only when absolutely necessary. Teams are well-exposed to the evidence base in children's mental health that supports the lack of benefit in placing youth in institutional care. As this baseline has remained stable over the year, coupled with a robust implementation of clinical review and supervision practices, it is likely that the baseline trend will remain the utilization pattern for youth in out-of-home treatment setting for the State. However, the reduce cost for out-of-home care suggest that youth are being served in less restrictive, more family-like settings or are experiencing shorter lengths of stay if out-of their homes.

CAMHD's comprehensive accountability and service system demonstrated further improvements in the quarter. Overall in the reporting period, CAMHD continued to demonstrate significant sustainability of services and service-delivery infrastructure. All measures of sustainability realized strong performance or full achievement of performance goals. Continual performance management of service delivery and infrastructure is a key commitment at all levels of the CAMHD service system.